31A-29-101. Short title.

This chapter is known as the "Comprehensive Health Insurance Pool Act."

Enacted by Chapter 232, 1990 General Session

31A-29-102. Purpose.

The purpose of the Comprehensive Health Insurance Pool Act is to provide access to health care insurance coverage to residents of Utah who are denied adequate health care insurance and are considered uninsurable.

Amended by Chapter 385, 2008 General Session

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage, as defined in Section 31A-1-301.

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

(4) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

(5) "Health benefit plan":

(a) is defined in Section 31A-1-301; and

(b) does not include a plan that:

(i) (A) has a maximum actuarial value less than 100% of a health benefit plan described in Subsection (5)(c); or

(B) has a maximum annual limit of $100,000 or less; and

(ii) meets other criteria established by the board.

(c) For purposes of Subsection (5)(b)(i)(A) the health benefit plan shall:

(i) be a federally qualified high deductible health plan;

(ii) have a deductible that has the lowest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law; and

(iii) not exceed an annual out-of-pocket maximum equal to three times the amount of the deductible.

(6) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(7) "Health care insurance" is defined in Section 31A-1-301.

(8) "Health care provider" has the same meaning as provided in Section 78B-3-403, with the exception of "licensed athletic trainer."

(9) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(10) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(11) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(a) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(b) coverage through:

(i) a health maintenance organization;

(ii) a preferred provider prepayment;

(iii) group practice;

(iv) individual practice plan; or

(v) health care insurance;

(c) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(d) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(e) coverage by Medicare or other governmental benefit.

(12) "HIPAA" means the Health Insurance Portability and Accountability Act.

(13) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act.

(14) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state;

(b) a health maintenance organization; or

(c) a self-insurer not subject to federal preemption.

(15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

(16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq., as amended.

(17) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

(18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

(19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

(20) "Pool policy" means a health benefit plan policy issued under this chapter.

(21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

(22) (a) "Resident" or "residency" means a person who is domiciled in this state.

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

(23) "Third party administrator" has the same meaning as provided in Section 31A-1-301.

Amended by Chapter 104, 2013 General Session

31A-29-104. Creation of pool -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Comprehensive Health Insurance Pool," a nonprofit entity within the Insurance Department.

(2) The pool shall be under the direction of a board of directors composed of 12 members.

(a) The governor shall appoint 10 of the directors with the consent of the Senate as follows:

(i) two representatives of health insurance companies or health service organizations;

(ii) one representative of a health maintenance organization;

(iii) one physician;

(iv) one representative of hospitals;

(v) one representative of the general public who is reasonably expected to qualify for coverage under the pool;

(vi) one parent or spouse of such an individual;

(vii) one representative of the general public;

(viii) one representative of employers; and

(ix) one licensed producer with an accident and health line of authority.

(b) The board shall also include:

(i) the commissioner or the commissioner's designee; and

(ii) the executive director of the Department of Health or the executive director's designee.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) Six board members are a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

Amended by Chapter 286, 2010 General Session

31A-29-105. Contents of plan.

The plan of operation submitted by the board to the commissioner shall:

(1) demonstrate that any and all assumptions of risk or liability by the pool shall be based on sound financial and actuarial principles reviewed and established in advance by the board and approved by the commissioner;

(2) establish procedures in compliance with Title 51, Chapter 7, State Money Management Act, and accounting policies and procedures established by the Division of Finance, for handling and accounting for assets and money of the pool;

(3) establish regular times and places for meetings of the board;

(4) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(5) contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

(6) establish procedures to pay claims under the pool;

(7) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred; and

(8) provide for the establishment of a mechanism to promote and publicize the existence of the plan, the eligibility requirements and procedures for enrollment in the plan, and to maintain public awareness of the plan.

Amended by Chapter 20, 1995 General Session

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall:

(a) have the specific authority to enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial

function appropriate to the operation of the pool;

(d) (i) close enrollment in the plans issued by the pool and cancel the plans issued by the pool in accordance with the plan of operation approved by the commissioner; and

(ii) close out the business of the pool in accordance with the plan of operation, including processing and paying valid claims incurred by enrollees prior to the date enrollment is closed under Subsection (1)(d)(i);

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool and to close pool business in accordance with Subsection (1)(d);

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual and a final audit of its operations by the state auditor;

(h) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

(i) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

(j) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

(k) administer the Pool Fund;

(l) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter;

(m) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products; and

(n) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage, regardless of preexisting conditions, under PPACA.

(2) (a) The board shall prepare and submit an annual and final report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-29-107. Powers of commissioner.

(1) The commissioner shall, after notice and hearing, approve the plan of

operation if the commissioner determines that the plan will assure the fair, reasonable, and equitable administration of the pool.

(2) The plan shall be effective upon the commissioner's written approval.

(3) If the board fails to submit a proposed plan of operation by January 1, 1991, or any time thereafter fails to submit proposed amendments to the plan of operation within a reasonable time after requested by the commissioner, the commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

(4) Rules promulgated by the commissioner shall continue in force until modified by him or until superseded by a subsequent plan of operation submitted by the board and approved by the commissioner.

(5) The commissioner may designate an executive secretary from the department to provide administrative assistance to the board in carrying out its responsibilities.

Amended by Chapter 168, 2003 General Session

31A-29-108. Examination -- Financial report.

(1) The pool is subject to examination by the commissioner.

(2) By December 1 of each year, the board shall submit to the commissioner an audited financial report for the preceding fiscal year in a form approved by the commissioner.

Amended by Chapter 194, 2001 General Session

31A-29-109. Policy forms.

All policy forms issued by the pool shall conform in substance to forms developed by the board and shall be filed with the commissioner before they are issued.

Amended by Chapter 168, 2003 General Session

31A-29-110. Pool administrator -- Selection -- Powers.

(1) The board shall select a pool administrator in accordance with Title 63G, Chapter 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) ability to manage medical expenses;

(b) proven ability to handle accident and health insurance;

(c) efficiency of claim paying procedures;

(d) marketing and underwriting;

(e) proven ability for managed care and quality assurance;

(f) provider contracting and discounts;

(g) pharmacy benefit management;

(h) an estimate of total charges for administering the pool; and

(i) ability to administer the pool in a cost-efficient manner.

(2) A pool administrator may be:

(a) a health insurer;

(b) a health maintenance organization;

(c) a third-party administrator; or

(d) any person or entity which has demonstrated ability to meet the criteria in Subsection (1).

(3) The pool administrator shall serve for a period of three years, with yearly extension options until the operations of the pool are closed pursuant to Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract between the board and the administrator.

(4) The pool administrator is responsible for all operational functions of the pool and shall:

(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by statute to be confidential;

(b) perform all marketing, eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;

(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from enrollees;

(d) perform all necessary functions to assure timely payment of benefits to enrollees, including:

(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and

(ii) evaluating the eligibility of each claim for payment by the pool;

(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which reports shall be determined by the board;

(f) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and submit a report of this information to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and

(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Amended by Chapter 425, 2014 General Session

31A-29-111. Eligibility -- Limitations.

(1) (a) Except as provided in Subsection (1)(b) and Subsection 31A-29-106(1)(d), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare,

except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. Sec. 300gg;

(vi) the individual's health condition does not meet the criteria established under Subsection (5);

(vii) the individual is eligible for coverage under an employer group that offers a health benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) the individual is covered under any other health benefit plan;

(ix) except as provided in Subsections (3) and (6), at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application; or

(x) the individual's employer pays any part of the individual's health benefit plan premium, either as an insured or a dependent, for pool coverage.

(2) (a) Except as provided in Subsection (2)(b) and Subsection 31A-29-106(1)(d), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual is eligible for a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. Sec. 300gg;

(iii) the individual is covered under any other health benefit plan;

(iv) the individual is eligible for coverage under an employer group that offers a health benefit plan or self-insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(vi) the individual is an inmate of a public institution; or

(vii) the individual's employer pays any part of the individual's health benefit plan

premium, either as an insured or a dependent, for pool coverage.

(3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health care insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

(b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

(4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).

(6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose individual health care insurance coverage was involuntarily terminated, is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii) and (x).

(b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the termination date of the previous individual health care insurance coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous individual coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived to the extent to which the waiting period was satisfied under the individual health insurance plan.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-29-112. Medicaid recipients.

(1) If authorized by federal statutes or rules, an individual receiving Medicaid benefits may continue to receive those benefits while satisfying the preexisting condition requirements established by Section 31A-29-113 and the terms of the pool policy issued under this chapter.

(2) If allowed by federal statute, federal regulation, state statute, or rule, the Department of Health shall allocate premiums paid to the pool by an individual receiving Medicaid benefits to that individual's spenddown for purposes of the Medicaid program.

(3) (a) If an individual continues to receive Medicaid benefits after the requirements for a preexisting condition are satisfied, the pool administrator may not issue a pool policy or allow that individual to receive any benefit from the pool.

(b) If an individual continues to receive Medicaid benefits when the requirements for a preexisting condition are satisfied, the pool administrator shall give any premiums collected by it during the preexisting conditions period to the Medicaid program.

(4) (a) If an enrollee becomes eligible to receive Medicaid benefits, the enrollee's coverage by the pool terminates as of the effective date of Medicaid coverage.

(b) The pool administrator shall:

(i) include a provision in the pool policy requiring an enrollee to provide written notice to the pool administration if the enrollee becomes covered by Medicaid; and

(ii) terminate an enrollee's coverage by the pool as of the effective date of the enrollee's Medicaid coverage when the pool administrator becomes aware that the enrollee is covered by Medicaid.

(5) If an individual terminates coverage under Medicaid and applies for coverage under a pool policy within 62 days after terminating the coverage, the individual may begin coverage under a pool policy as of the date that Medicaid coverage terminated, if an individual meets the other eligibility requirements of the chapter and pays the required premium.

(6) Notwithstanding Subsections 31A-29-111(1)(b)(i) and (2)(b)(i), an individual is eligible for coverage by the pool if the requirements of Section 31A-29-111 are met and if:

(a) the individual's eligibility for Medicaid requires a spenddown, as defined by rule, that exceeds the premium for a pool policy; or

(b) the individual is eligible for the Primary Care Network program administered by the Department of Health.

Amended by Chapter 253, 2012 General Session

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board

for the health care services and items rendered during times for which benefits are extended under the pool policy.

(c) Section 31A-21-313 applies to coverage issued under this chapter.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(5) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(6) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (6)(a) does not apply to a HIPAA eligible individual.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) The pool will waive the preexisting condition exclusion described in Subsections (6)(a) and (7)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

(b) If this Subsection (8) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(9) Covered benefits available from the pool may not exceed a $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Amended by Chapter 425, 2014 General Session

31A-29-114. Deductibles -- Copayments.

(1) (a) A pool policy shall impose a deductible on a per calendar year basis.

(b) At least two deductible plans shall be offered.

(c) The deductible is applied to all of the eligible medical expenses incurred by the enrollee until the deductible has been satisfied. There are no benefits payable before the deductible has been satisfied.

(d) The pool may offer separate deductibles for prescription benefits.

(2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess of the mandatory deductible.

(b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool policy.

(3) The board shall establish maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee for each of the deductible plans offered under Subsection (1)(b).

(4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments under Subsection (3), the board may establish a coinsurance requirement to be imposed on eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

(b) The circumstances in which the coinsurance authorized by this Subsection (4) may be imposed shall be designated in the pool policy.

(c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to exceed 5% of eligible medical expenses.

(5) The limits on maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee under this section may not include out-of-pocket payments for prescription benefits.

Amended by Chapter 425, 2014 General Session

31A-29-115. Cancellation -- Notice.

(1) On the date of renewal, the pool may cancel an enrollee's policy if:

(a) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111(5); and

(b) the pool has provided written notice to the enrollee's last-known address no less than 60 days before cancellation.

(2) The pool may cancel an enrollee's policy at any time if:

(a) the pool has provided written notice to the enrollee's last-known address no less than 15 days before cancellation; and

(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;

(ii) there is nonpayment of premiums; or

(iii) the pool determines that the enrollee does not meet the eligibility requirements set forth in Section 31A-29-111, in which case:

(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;

(B) retroactive termination may not exceed three years; and

(C) the board's remedy under this Subsection (2)(b) shall be a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with

Subsection 31A-29-119(3).

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session
Amended by Chapter 425, 2014 General Session

31A-29-116. Notice of availability.

The commissioner shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, governing notice of availability which is to be given by insurers to potential enrollees in the pool.

Amended by Chapter 382, 2008 General Session

31A-29-117. Premium rates.

(1) (a) Premium charges for coverage under the pool may not be unreasonable in relation to:

(i) the benefits provided;

(ii) the risk experience; and

(iii) the reasonable expenses provided in the coverage.

(b) Separate schedules of premium rates based on age and other appropriate demographic characteristics may apply for individual risks.

(2) Small employer carriers, as defined in Section 31A-30-103, shall annually inform the commissioner by February 1 of the carrier's:

(a) small employer index premium rates as of January 1 of the current and preceding year; and

(b) average percentage change in the index premium rate as of January 1, of the current and preceding year.

(3) (a) Premium rates may be adjusted by the board on a biannual basis, for an effective date of January 1 and July 1.

(b) In adjusting premium rates, the board shall:

(i) consider the average increase in small employer index rates for the five largest small employer carriers submitted under Subsection (2); and

(ii) be subject to Subsection (1).

(4) The board may establish a premium scale based on income. The highest rate may not exceed the expected claims and expenses for the individual.

(5) If an individual is HIPAA eligible, the maximum premium rate for that individual may not exceed the amount permitted under HIPAA.

(6) All rates and rate schedules shall be submitted by the board to the commissioner for approval.

Amended by Chapter 40, 2007 General Session

31A-29-119. Benefit reduction.

(1) The pool shall be the last payer of benefits whenever any other benefit is available.

(2) Benefits otherwise payable under pool coverage shall be reduced by:

(a) all amounts paid or payable through any other health benefit plan or any limited health benefit plan, including a self-insured plan;

(b) all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault; and

(c) any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program.

(3) The board shall have a cause of action against an enrollee for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this Subsection (3).

Amended by Chapter 385, 2008 General Session

31A-29-120. Enterprise fund.

(1) There is created an enterprise fund known as the Comprehensive Health Insurance Pool Enterprise Fund.

(2) The following funds shall be credited to the pool fund:

(a) appropriations from the General Fund;

(b) pool policy premium payments; and

(c) all interest and dividends earned on the pool fund's assets.

(3) All money received by the pool fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The pool fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The pool fund shall comply with Title 63A, Utah Administrative Services Code.

Amended by Chapter 168, 2003 General Session

31A-29-121. Tax exemption.

The pool is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

Enacted by Chapter 232, 1990 General Session

31A-29-122. Immunity.

There is no liability on the part of and no cause of action of any nature may arise against any member of the board, the board's agents or employees, the executive director, the administrator or its agents or employees, or the commissioner for any action or omission by them in effecting the provisions of this chapter.

Amended by Chapter 168, 2003 General Session

31A-29-123. Exemption.

Other than where specifically stated above, the pool shall be exempt from all requirements contained in Title 31A.

Enacted by Chapter 232, 1990 General Session